

**United States General Accounting Office  
Statement of William J. Scanlon, Director  
Health Financing and Systems Issues  
Health, Education, and Human Services Division**

Mr. Chairman and Members of the Committee

We are pleased to be here today to discuss steps the Health Care Financing Administration (HCFA) could take to help beneficiaries make more informed choices among Medicare health plans. In 1961 we reported to you that beneficiaries received little or no comparative information on Medicare health maintenance organizations (HMO). Among other things, we recommended that HCFA produce plan comparison charts, require plans to use standard formats and terminology in key aspects of their marketing materials, and publicize readily available plan performance indicators such as disenrollment rates. In addition, Medicare+Choice provisions under the Balanced Budget Act of 1997 (BBA) authorize new health plan options for Medicare beneficiaries and mandate that HCFA provide beneficiaries with comparative information about the Medicare+Choice options.

My remarks today will focus on the extent to which HCFA's Medicare+Choice information development efforts are likely to (1) enable beneficiaries to readily compare benefits and out-of-pocket costs using plan brochures and (2) facilitate the agency's approval of plans' marketing materials and other administrative work required of both HCFA and the health plans. I am basing these remarks on our ongoing work for this Committee. I will also discuss the findings from our recent report on HMO disenrollment rates and how data that HCFA already collects, but does not publish, may be useful to beneficiaries.

In summary, HCFA has begun making certain plan-specific information available to beneficiaries. For example, in March of this year, HCFA posted summary information on health plans' premiums, out-of-pocket costs, and benefits on the Internet. HCFA is also working to provide a printed version of this information directly to beneficiaries and meet other BBA information dissemination requirements.

These efforts, however, do not address the problem beneficiaries face in trying to carefully evaluate their health plan choices using the plans' summaries of benefits and other marketing materials. These materials are a major source of health plan information. Currently, plans use widely varied formats and definitions of benefits in the materials they distribute to beneficiaries. As we reported in 1996, this lack of common formatting and language made it difficult, if not impossible, for beneficiaries to rely on HMOs' marketing literature to compare benefits and premiums. Preliminary results from our current work on HMOs' prescription drug benefit—a benefit that attracts many Medicare beneficiaries to managed care—suggest this situation continues to exist. Our current work also suggests that critical information is sometimes missing from plans' marketing materials.

The diverse formats and terms also cause problems for health plans and HCFA staff. Without HCFA's specifying common standards for plans' marketing materials, agency staff have wide discretion when deciding to approve or reject these documents. Plan representatives and HCFA staff we spoke with said that this latitude leads to inconsistent HCFA decisions, unnecessary delays, and extra costs. The lack of required standards similarly affects the efficient development of comparative benefits information. Under current circumstances, agency staff must comb through dissimilar information submitted by plans for HCFA's contract approval process and contact the plans to clarify the information before producing benefit comparison summary charts.

To help beneficiaries evaluate their health plan options, HCFA could move faster to publish readily

available plan performance indicators such as plans' disenrollment rates. With this information, beneficiaries could then decide to seek more information about a plan before enrolling.

HCFA could better serve beneficiaries, reduce burdens on health plans, and leverage its own resources by setting information standards for health plans' marketing literature. We believe, therefore, that HCFA should adopt the recommendations we made in 1996 and require plans to use standard formats and terminology in their benefit descriptions. In addition, HCFA should use plan performance data it already collects to help inform beneficiaries' health plan decisions.

## **BACKGROUND**

Most beneficiaries live in areas where they can choose to receive Medicare benefits either through a managed care plan or through traditional fee-for-service Medicare. Of the 6 million beneficiaries enrolled in Medicare managed care, approximately 90 percent are in "risk-contract" HMOs. Medicare pays these HMOs a fixed, per beneficiary fee, regardless of what the HMO spends for each beneficiary's health care. These plans are called "risk" HMOs because the HMO assumes the financial risk of providing care for the amount Medicare pays.

Although HMOs are required to cover all traditional Medicare benefits, many also provide additional services, such as outpatient prescription drugs, routine physical examinations, and hearing aids. In addition, plan costs can vary: some HMOs charge a monthly premium (in addition to Medicare's part, B premium), but others do not. Except for emergency services, HMO enrollees must generally receive all covered care through health care professionals designated by their plans.

The number of Medicare beneficiaries enrolled in risk HMOs has more than doubled in the last 3 years, from 2.3 million in December 1994 to 5.2 million in December 1997. The number of Medicare risk HMOs also increased, from 154 to 307, in the same time period. The growth in Medicare managed care enrollees and plans is expected to continue, fueled in part by the BBA, which provided for new types of Medicare managed care plans and increased plan payments in many areas that previously lacked a fee-for-service alternative. Unlike other large health care purchasing organizations, HCFA has not routinely provided plan-specific information directly to beneficiaries. However, the BBA now requires HCFA to distribute comparative information that can help beneficiaries interested in managed care select a health plan. In addition, HMOs will continue to advertise and distribute summaries of benefits as part of their marketing efforts to enroll new members.

HCFA, through its regional offices, approves the HMOs' marketing materials before plans use them. HCFA regional offices also oversee HMO marketing and enrollment efforts by reviewing plans' sales practices and responding to beneficiaries' complaints. HMOs must include certain explanations in their marketing materials, such as provider restrictions, but otherwise have wide latitude in what information is included and how it is presented.

Each year, as part of the contracting process, HMOs submit to HCFA detailed information on their proposed benefits, premiums, and other beneficiary out-of-pocket costs. HCFA's central office reviews these proposals for compliance with Medicare regulations and approves the contracts.

## **STANDARD BENEFIT DESCRIPTIONS COULD HELP BENEFICIARIES COMPARE PLANS' BENEFITS AND EASE BURDEN ON PLANS AND AGENCY STAFF**

Although HCFA has efforts under way to publish comparative information on Medicare+Choice plans,

it has not taken the steps needed to enable beneficiaries to make similar comparisons using individual plans' marketing materials. The absence of standards for format and terminology used to describe benefits and out-of-pocket costs limits the usefulness of these materials for comparison purposes. Such standardization would help beneficiaries in comparing health plans and lessen the administrative burden on both HCFA and the plans. Extending these standards, to the information that plans provide to HCFA in their contract submissions would facilitate the agency's efforts to assemble comparative information.

### **HCFA Has Efforts Under Way to Disseminate Information on Medicare+Choice Plans**

Until this year, HCFA produced little comparative information on Medicare HMOs. In March 1998, HCFA made available a database it calls "Medicare Compare," which posts summary information on the Internet comparing health plans' benefits and out-of-pocket costs. HCFA intends to update the database and add plan performance indicators as they become available in the coming months and years. In addition, HCFA plans to include comparison charts in the next Medicare Handbook to be mailed to beneficiaries. Agency staff are also conferring with seniors' advocacy groups to determine how best to inform beneficiaries of their new Medicare+Choice options.

### **Lack of Standard Format and Terminology in Marketing Materials Hinders Ready Comparison of Plans' Benefits and Costs**

Federal employees and retirees can readily compare benefits among health plans in the Federal Employees Health Benefits Program (FEHBP) because the Office of Personnel Management, which administers FEHBP, requires plan brochures to follow a common format and use standard terminology. In contrast, HCFA does not require Medicare HMOs to use standardized formats or terms, including definitions, in their marketing materials. Consequently, Medicare beneficiaries cannot easily use plans' marketing materials to compare benefit packages.

Neither HCFA's Medicare HMO/Competitive Medical Plan (HMO/CMP) Manual nor its supplemental Medicare Managed Care National Marketing Guide requires standardization in plan materials. In fact, the manual, which provides guidance on the contents of plans' marketing materials and HCFA's process for reviewing these materials, specifically states, "HCFA does not mandate a format or style for ... marketing materials other than requiring that the member rules be written and that the marketing materials ... be understandable to the average beneficiary." HCFA's marketing guidelines do contain model language and documents HMOs can adopt, but plans are not required to use the models. Without required standards from HCFA, HMOs are left to their individual discretion, as we reported in 1996.

We recently asked the eight Medicare HMOs serving the Tampa, Florida, area to send us their marketing materials. We received a wide array of brochures, pamphlets, and other written documents. Although all plans provided benefit summaries, the formats and benefit categories varied considerably from plan to plan. This lack of consistency may impair a beneficiary's ability to compare benefits and related costs. For example, we found that only five Tampa plans mention mammograms in their benefit summaries—even though all plans covered mammograms. Most plans listed mammograms under the benefit category of preventive services. One plan, however, listed mammograms under hospital outpatient services. Consistent presentation is important because beneficiaries may rely on plans' benefit summaries for coverage and out-of-pocket cost information. Beneficiaries typically do not receive more detailed benefit descriptions until after they enroll in a plan.

The HMOs we reviewed also differed in the terms they used to describe the same benefit. Some plans used technical terms but did not define them. Consequently, beneficiaries could misinterpret important out-of-pocket costs or benefit restrictions. For example, some plans used the term "formulary" in

describing their drug benefit but did not explain what it meant. Beneficiaries reading a plan's marketing materials may not understand that use of nonformulary drugs may result in substantially higher out-of-pocket costs. To learn what "formulary" means when it is not defined in the marketing literature, beneficiaries would have to ask plan representatives or read the plan's "evidence of coverage"- a document normally provided to beneficiaries after they enroll in a plan.

### **Lack of Standards for Marketing Materials Can Result in Misleading Comparisons**

Seemingly straightforward benefit comparisons may be misleading because plans' marketing materials sometimes omit key details. Plan descriptions of prescription drug coverage, a benefit offered by many HMOs, illustrate how missing information can lead to erroneous conclusions about the value of plans' benefits.

Under the best of circumstances, the relative value of plans' prescription drug coverage may be hard to compare. For example, plans that have formularies often set one copayment amount for formulary drugs and another, higher copayment for nonformulary drugs. Beneficiaries' out-of-pocket costs for such plans depend both on the specific drugs included in the formularies and the two copayment amounts.

Beneficiaries may use a plan's stated annual dollar limit, or cap, to judge the drug benefit's consumer value. For example, beneficiaries may assume that an HMO offering prescription drug coverage up to a \$1,200 annual cap has a more generous benefit than another HMO offering coverage up to \$1,000. This comparison may be misleading, however. Plans differ in how they calculate the dollar amount of drugs used by beneficiaries. Some plans use retail prices to compute this amount. Others may use drugs' average wholesale prices (AWP) or a lower price discounted from AWP to calculate a member's total drug usage in dollars.

One HMO gave us an illustration of how the value of a drug benefit depends on whether drug cost is measured by retail prices, AWP, or discounted AWP. The HMO used the drug Prilosec for the example because it is one of the brand-name drugs most commonly prescribed for its Medicare members. According to the plan, the retail price of Prilosec is \$123 and the AWP is \$101. The HMO said it computes the dollar amount of a member's Prilosec usage using a discounted AWP of about \$91 per prescription. If the plan used AWP, or the even higher retail price, members would receive fewer prescriptions before reaching the annual dollar coverage limit. The consumer value of a drug benefit could vary substantially between two HMOs with the same annual cap if they used different prices to compute drug usage.

In addition, HMOs' marketing materials do not always disclose key details that beneficiaries need to make accurate comparisons. For example, marketing materials from several Tampa HMOs did not mention what prices plans used (that is, retail, AWP, or some price below AWP) to compute the dollar amount of members' drug use. One-half of the plans did not disclose that their prescription benefits involve formularies. Similarly, plan materials often failed to inform members that they face higher out-of-pocket costs if they choose a brand-name drug when a generic drug is available.

### **Lack of Standards Slows HCFA Review of Plans' Marketing Materials**

HCFA's lack of standards for benefit descriptions also complicates HCFA review of marketing materials and delays their distribution. HMO officials said that HCFA's Medicare Managed Care National Marketing Guide provides broad criteria for plan materials sent to beneficiaries. It does little to ensure that HCFA's regional office staff will review plans' marketing materials consistently and uniformly nationwide-a problem we noted in 1996 when the guidelines were being developed.

Individual HCFA staff have wide discretion in approving and rejecting plans' marketing materials. HMOs report that this discretion leads to inconsistent decisions and unnecessary delays in the development and distribution of plan materials. For example, plans report that HCFA reviewers frequently require changes to materials that were previously approved by other HCFA reviewers. These changes may delay printing or limit the use of materials already printed and increase plans' costs. Plans report being particularly disturbed by inconsistent HCFA decisions based on individual reviewers' preferences. For example, one reviewer may require a plan to use the term "contracting provider" instead of "participating provider," even though both terms are approved by HCFA's marketing guidelines. The rework caused by inconsistent reviews is time consuming and costly for both HCFA and the plans.

HMO representatives reported that corporate purchasers often require plans to use standard language. The HMO representatives suggested that Medicare information standards could reduce the amount of time HCFA and plan staff spend reviewing and reworking marketing materials. All of the plans' representatives we spoke with said that they would be in favor of such standards developed in conjunction with all relevant parties.

### **Standard Format and Terminology in Plans' Contract Submissions Could Facilitate HCFA's**

#### **Development of Comparative Information**

The lack of standards for benefit descriptions in plans' contract submissions hinders HCFA's efforts to produce benefit comparison charts and complicates the agency's reviews of plans' marketing materials. As part of the normal Medicare contracting process, HMOs regularly submit to HCFA detailed information on their benefit packages. HCFA's Center for Health Plans and Providers (CHPP) reviews these packages and approves plans' Medicare contracts. However, HMOs are not required to conform to standard formats, language, or descriptions in their contract submissions. Consequently, it is difficult for the Center for Beneficiary Services (CBS), HCFA's new unit responsible for providing information to beneficiaries, to develop benefit comparison summaries from these contract submittals. Instead, CBS has to recontact HMOs and request benefit information for its own use. Moreover, HCFA regional offices, which must review plans' marketing materials for accuracy, cannot easily rely on contract submissions to confirm required premiums, copayments, and benefits.

HCFA recognizes that the agency needs to standardize the information that plans submit for contract approval. HCFA staff said this would reduce the administrative burden on health plans and the agency. In addition, the agency could more readily produce comparison charts and check HMOs' marketing materials for accuracy. According to HCFA staff, the agency has a group working on revising the contract approval process. Implementation of new contract information requirements, however, is targeted for 2001 or later.

### **ANALYSIS AND PUBLICATION OF DISENROLLMENT RATES AND OTHER HCFA DATA COULD AID CONSUMER DECISION-MAKING**

HCFA collects a considerable amount of data for program administration and contractor oversight that can indicate beneficiaries' relative satisfaction with HMOs in their market. These indicators include statistics on beneficiary disenrollment and complaints. Of these indicators, disenrollment rates may be most useful to beneficiaries trying to distinguish among plans. Our analyses, contained in our 1996 report and our most recent report, showed that disenrollment rates vary widely among HMOs that serve the same market. However, HCFA has not systematically analyzed or published Medicare HMOs'

disenrollment rates. Nor has HCFA yet surveyed beneficiaries who enrolled from HMOs to learn why some plans have relatively high disenrollment rates.

### **HCFA Could Move More Quickly to Publish HMOs' Disenrollment Rates and Other Plan Performance Indicators**

Relative disenrollment rates may serve as broad indicators of HMO enrollee satisfaction even though they cannot pinpoint the causes of disenrollment. They cannot distinguish, for example, disenrollment caused by quality or service problems from disenrollment caused by price or value competition. Nonetheless, beneficiaries who are considering joining a managed care plan and know relative disenrollment rates may want to seek explanations for plans' high disenrollment rates.

Ten years ago, we first reported that some Medicare HMOs had high disenrollment rates. In 1995, we recommended that HCFA publish HMOs' disenrollment rates. HCFA took no action on our recommendation, even though the agency already collects, for plan payment purposes, the data necessary to calculate disenrollment rates. In 1996, we reported that HMOs' disenrollment rates varied widely in the two market areas we studied: Miami and Los Angeles. We also restated our recommendation that HCFA publish plans' disenrollment rates.

Our most recent report shows that many HMOs nationwide had relatively high voluntary disenrollment rates. In many markets, the highest disenrollment rates exceeded the lowest rate by more than fourfold. In a few markets, the range in disenrollment rates was even wider. For example, in Houston, Texas, the highest disenrollment rate was nearly 56 percent, while the lowest rate was 8 percent.

The BBA includes provisions requiring HCFA to publish plans' disenrollment rates. HCFA officials told us they intend to meet that requirement by publishing rates sometime in 1999. HCFA could act sooner, however, to provide this information to beneficiaries. Because HCFA already collects the necessary data, plans would not be burdened by providing additional data. HCFA could publish disenrollment rates this year. In fact, some HCFA regional offices have periodically distributed these data to HMOs. Medicare HMOs would have a strong incentive to improve their performance if HCFA published the disenrollment rates for 0 plans.

Rates of complaints to HCFA from HMO enrollees can also indicate relative satisfaction levels. Some states and large purchasers routinely publish plan rankings based on complaint rates. This information would be relatively simple for HCFA to compile and publish. Although some HCFA offices track the complaints they receive, no HCFA office publishes HMO-specific complaint rate statistics.

### **Full Assessment of Beneficiary Satisfaction With HMOs Unavailable for at Least 2 Years**

HCFA's initial efforts to assess beneficiaries' satisfaction with individual Medicare HMOs may be seriously flawed. Recently, HCFA sponsored a survey of HMO members, known as the Consumer Assessment of Health Plans Study. HCFA intends to release the results later this year to help beneficiaries compare the plans' ability to satisfy their members. Shortcomings in the survey's sampling methodology, however, will greatly limit the usefulness of the results and preclude accurate comparisons.

The consumer assessment study includes only beneficiaries who have remained in the same health plan for at least 12 months. Beneficiaries who left dissatisfied or left for other reasons are excluded. A survey of only those beneficiaries who are satisfied enough to remain enrolled in their health plans may yield biased results. For example, we spoke with representatives of one HMO that conducted an annual

member survey. Because the survey showed that 90 percent of its members were satisfied, HMO officials did not understand why their plan had a 40-percent disenrollment rate. When the HMO conducted a survey of disenrollees, however, it discovered that many beneficiaries had left to obtain better benefits at other HMOs.

HCFA is planning to survey Medicare HMO disenrollees in the future. If designed appropriately, such a survey could help explain why some HMOs have high disenrollment rates. For example, survey results may indicate whether disenrollees left because of quality or access problems or because competing HMOs offered more generous benefits. The disenrollee survey instrument and methodology have not yet been defined, and, according to HCFA staff, the results will not be available until 2000 at the earliest.

## **CONCLUSIONS**

HCFA faces many new responsibilities and challenges in implementing Medicare+Choice. The success of the program depends in part on the agency's ability to set priorities and use resources efficiently. Although HCFA is working to produce information to help beneficiaries compare their health plan options, the agency could leverage its resources by setting information standards, especially for plans' marketing. The benefits would accrue not to the beneficiaries making comparisons but also to health plans and HCFA staff in the review and approval of plan documents. Similarly, HCFA could also take immediate advantage of the data it already collects to publish such performance indicators as annual disenrollment rates.

Mr. Chairman, this concludes my prepared statement. I am pleased to answer any questions you or other members of the committee may have.